UNITED STATES OF AMERICA

NATIONAL TRANSPORTATION SAFETY BOARD

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| Investigation of: | * | |
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| WMATA METRO TRAIN DERAILMANT | * | |
| IN ARLINGTON, VIRGINIA | * | Accident No.: RRD22LR001 |
| ON OCTOBER 12, 2021 | * | |
| | * | |

Interview of: ED DONALDSON, Director of Rail Operations
Control Center
Washington Metropolitan Area Transit Authority

Landover, Maryland

Saturday,
October 16, 2021

APPEARANCES:

STEPHEN JENNER, Investigator
National Transportation Safety Board

GREG KUPKA, Deputy Chief of Safety Department
Washington Metropolitan Area Transit Authority

BRUCE WALKER, Subject Matter Expert for Operations
Washington Metro Safety Commission

ED DONALDSON, Director of Rail Operations Control Center
Washington Metropolitan Area Transit Authority

I N D E X

I N T E R V I E W

MR. JENNER: Good morning, my name is Stephen Jenner and I am with the NTSB serving as the Operations and Human Performance Group Chairman for this accident.

Today is October 16th, 2021. We are here at the Carmen Turner Facility in Landover, Maryland, to conduct an interview with Mr. Ed Donaldson, who works for WMATA.

This interview is in conjunction with the NTSB investigation of the October 12th, 2021, derailment of a Metro train in Arlington, Virginia. The NTSB Reference No. is RRD22LR001. The purpose of this investigation is to increase safety and not assign fault, blame or liability.

Before we begin our interview and questions I'll just go around the table and introduce ourselves and please spell your name and list your title and who you're with. And again, I'm Stephen Jenner, S-T-E-P-H-E-N, J-E-N-N-E-R, Human Performance Investigator with the NTSB.

MR. KUPKA: Hi, my name is Greg Kupka, G-R-E-G, K-U-P-K-A, I am with the WMATA Safety Department, my title is Deputy Chief of Safety Assurance.

MR. DONALDSON: I'm Ed Donaldson, E-D, D-O-N-A-L-D-S-O-N, I am with WMATA and I am Director of the Rail Operations Control Center.

MR. WALKER: My name is Bruce Walker, Bruce, B-R-U-C-E, Walker, W-A-L-K-E-R, I'm with the Washington Metro Safety

Commission, my title is Subject Matter Expert Operations.

MR. JENNER: Terrific. Do we have your permission to tape record?

MR. DONALDSON: Yes.

MR. JENNER: Thank you.

MR. DONALDSON: Uh-huh.

INTERVIEW OF ED DONALDSON

BY MR. JENNER:

Q. With that in mind, if you would, just tell us about your background, anything relevant all the way up until your current position.

A. Okay. So I've been with WMATA now since -- I joined WMATA in August of last year. I'm sorry, in November of last year. Prior to that I was with the FAA, federal aviation administration, for a total of 29 years in various capacities in the air traffic organization.

I came to -- I retired from the FAA October the 31st of last year and I started with WMATA on November the 8th. I came about this position one day we were working from home during the pandemic and prior to me starting work -- I get up early so prior, so prior to me starting work I looked a number of news feeds and WTOP is one of my sources.

As I clicked on WTOP there was a banner that flashed that says, Metro's OCC has a toxic work environment and I had no idea what an OCC was. I clicked on it and I was going to get back to

that later on but then another banner popped up and it took me to the story and for whatever reason I delayed the start of my workday and I read that and it just explained some of the challenges that were being faced here in this operation, this control center.

And it also stated that they were doing a national search for a director, so had no intent at the time of doing anything different with the FAA, set and comfortable. So I clicked on it, it took me to a link and I put an application in and moved on with my day.

A couple of days later I got a call from the individuals that were leading the search for this position and we started that process so from the start of me actually clicking until about it was two to three weeks interviewed, received an offer and here I am so.

Q. All right. Did you in order to learn this position, what sort of training or OJT or anything along those lines did you have to go through?

A. Not really wasn't, it wasn't a lot from a technical point of view because this position is and as it was explained to me and as I ascertained, once I started, this is about leadership and professional development of the staff here in the OCC so and I've been very deliberate.

My technical knowledge is at a surface level and that's intentional to develop, to develop the staff and the folks that I

work with professionally I don't dive too deep into the weeds because you've got to give them the opportunity to perform the functions that they serve in.

So my role is more of a leadership and making sure that we have the resources and professional development.

Q. I see.

A. Uh-huh.

Q. Well so you've been here almost a year?

A. Almost, yeah.

Q. Have you observed any type of changes for better or for worse?

A. Yeah, so again taking the – taking the culture that existed previously and I won't go into that, Bruce is very familiar, Greg is familiar and I'm sure you've done some research on it, Steve. There were some things that needed to change and the change had already started prior to my arrival.

So I don't know what led up to the audit that was done by the WMSC but there was some type of catalyst that said that we need to take a really hard look at it, I don't know if it was a safety event or what, I never really delved into that too much.

I looked at the audit that came from the WMSC and so that was sort of my background and for me it was just simply a dearth of leadership to be totally honest with you and I think the leadership recognized that so they enacted some things and again prior to my arrival that sort of precipitated changes that needed

to be made.

There was a formation of a transformation team that said, we're going to take the current state of the OCC and make changes that we need in order to make sure that it goes this critical safety mission. So all that had got started prior to my arrival, I just sort of picked those things up as I came in the door.

Q. I see. So when you mentioned dearth of leadership how did that translate into the environment that you had observed?

A. Yeah. Brutally honest with you there was, there was, especially during events there was chaos and again I think that's well known where there's a lack of structure, a lack of procedures and processes.

You can have -- things are going to occur in systems, they absolutely are going to occur, especially in safety systems and then the other variable in that is safety systems that are responsible for moving people and vehicles, that's part of it.

You have to have an organization that's prepared to deal with the anomalies and from my initial impression was the OCC was in the process, it had been recognized that you needed to have those systems with those processes in place to deal with those things but we were not there yet, so it's a work in progress.

Q. Okay. So what changes if any are you responsible for?

A. So again the transformation team did a lot of heavy lifting prior to my arrival so some of the things that we saw, that I saw walking in the door, procedures, there were a lack of processes

and procedures just on basic administrative things. My number one item right after safety I would categorize this as 1A is training, the training program, again being brutally honest is abysmal.

You can't have an entity that's tasked with a critical safety function and not have an established structured training program where we can transfer knowledge between -- doesn't matter who walks in the door we should have a system in place to train them to operate within this system and it just wasn't there.

From academics to OJT, you know, all aspects of training. So that was the first thing that I noticed and that was a flag that was raised that I raised and fortunately leadership listened and so we started a process, that process was, one, there was a solicitation let out to bring in a company or an entity that does training, real training where that has ISDs, can develop a curriculum.

You have to match your academic, your curriculum to policy so they'll take that and having been through this with the FAA I know what that looks like, so once that company is identified, that vendor is identified they'll come in and we'll sit down with them and have those conversations because we're going to transform the training program from A to Z, that's going to be the first step.

Then after that it is the leadership and development piece and again I don't delve too deep into the technical portion of it because that's where my interest is, our greatest need is at the first line supervisor level because my observation is whatever

happened in the past you have people that were put in those positions that weren't trained properly to function the way that they need to to oversee a safety operation, so that development.

And, and it goes back to what we talked about originally which was the chaotics when you have a safety event. My understanding would be in the past a safety event would occur, you would have senior leadership rush into the room and yelling and things would ensue, very intentional when an event occurs, I'm not -- I don't come down into that environment.

I monitor it from my office when I'm here but I allow the team to work through the processes that are in place. One, they learn from it and, two, you have to remove all the distractions from that environment so they can concentrate on what they need to do.

Q. I see. Okay. So as you're describing the chaotic event and senior leadership coming in and yelling, has that improved?

A. Oh, yeah, stopped that. So it would be the person who sat in this slot previously and again I'm going by from what I saw from the audit and from when I talked to the people that are there and it's very intentional, there has to be a calmness in any safety event and you just go to your training, you fall back to your training.

So you cover things from A to Z so you don't miss D&S (ph.) and you take the risk out of that environment. But you've got to take all of those distractions out so you don't run downstairs and

do in the room and start pointing and yelling.

Q. Right.

A. Yeah.

Q. Let me give you an opportunity to tell me other improvements that you've been part of?

A. Yeah. So for the first piece is right after training one of my first observations we didn't have senior operational oversight on a 24/7, 365 basis and that's huge because if I had -- if we had the operation I have people that are designated to oversee it and they weren't present, that's an issue.

And so the first thing we did was a management reorganization and basically we took all the slots that were designated as managerial and recompeted them, so people had to -- the perception was I'm making people bid for their jobs.

And, no, those jobs don't belong to an individual they belong to the company so and the initial assessment was didn't have the right people in the right places. So we reorged, redesignated slots, did different slots but everybody that was in those slots had to recompete, some were successful, some weren't.

And so it's sort of like, you know, the proverbial saying the crème rises to the top and so we want the best of the best, so the potential to be the best in those slots. So that was the first piece the (indiscernible) reorg. Then we instituted a very intensive training program for the managerial staff and really for the entire staff of the (indiscernible) to let them know why we

were doing the reorg.

And then we did leadership training, development training just a litany of different things, this whole curriculum in order to get people prepared for this new structure. And the intent of the new structure is to prepare us for when we have safety events, the day-to-day pretty much can cover that but when we have safety events we need to have the infrastructure in place to manage that event.

And without the chaos and to make sure I have enough managers to oversee that entire process. So the long answer to your first question, management reorg training and then conversations that really set what our expectations and standards are.

This environment, a lot of the change is based on previous culture and the culture, one thing I do enjoy about WMATA is that there is a willingness to have people do different things and there's pretty much an expectation, like start (indiscernible) transition to training and you do other things, so that give you technical diversity.

What was lacking and is lacking is how to deal with people and so that's where the conversations would come in on expectations and standards because when you had those events people, you know, not only senior leadership but our first line supervisors it was -- it seemed like everybody was yelling and screaming at people and you can't do that in this environment because you need calmness to envelope the arena in order to do the

things that need to be done to get us out of that event.
Q. Right.
A. Yeah.
Q. You used the term event; can you give me an example or a couple examples of what an event is?
A. Yeah, anything, any abnormalities in the system. So we had, Glenmont we had a pull apart, Rhode Island Avenue we had a situation that developed, you had a rollback, you had customers evacuating onto the roadway, I mean, just a litany of different things that occurred with that but anything that's outside of our normal area of operations.
Q. And how often might those happen?
A. They, it's feast or famine.
Q. Okay.
A. Yeah, in air traffic we used to say they come in threes. So we've had since I've been here we've had -- so we had Glenmont, we had Rhode Island Avenue. We've had a couple, you know, there's no real timeframe associated with them but they --
Q. Right.
A. You just have to be aware and setup for when they do occur.
Q. All right. So, certainly not a daily or not necessarily a weekly occurrence?
A. Oh, no. No.
Q. Maybe every few months is what you're thinking of this as in that, yeah.

A. They're random.
Q. Okay. So where do you think things are now and where do they need to go?
A. If we go from zero to 100 -- so the management reorg took place on August 23rd and putting that structure in place and that along with the efforts of the transformation team, I would say if I go from a scale of 0 to 100 we're probably at 55 to 60 percent to where we need to be.

Because it's getting people to recognize and understand that there has to be structured processes and foundational processes in this arena and that's for when the -- that balloon goes up and we have an event, a safety event that occurs we -- are fall back is our training and we're trained to a level to say, there's no -- we don't get manic with our reaction, we use checklists, we use our processes and our procedures and we go from A, B, C, D and E.

We can't skip steps because that brings risk in but follow the processes and trust the processes. And so about 60 percent of where we need to be because I need to get -- we need to get people recognizing to rely on those processes and not - I don't need, I don't need ballerinas stepping out or people drawing outside of the lines, follow the processes and then transition back to our normal pace of operations.
Q. I see. Let me just throw out a question, if you use the same scale, 0 to 100 and apply that to the -- when you were an air traffic controller before you left --

A. Yeah.
Q. -- where would you put a number on the air traffic controller when you were toward the end of your career there?
A. Probably about 95 percent and the simple reason, we started that process when you walked in the door and it was understood so if you were hired as an air traffic controller you would go to our academy in Oklahoma City and it was understood that the safe operation on a national airspace system is our number one priority.

And we from a person we do not tolerate anybody that would jeopardize that or impeded in what we would do, so our mission was our number one part, the safe execution of the day-to-day air traffic operation was a priority and it started at the top and it went all the way down to the bottom and it started the second he walked in the door.

So that's the goal here, so we're taking everything from the hiring processes that we use, you've got the raw material that to get in the door, you've got to recognize that somebody walking in the door, you have to identify people that have the capacity to come in and learn a system and the operate within that system.

So that's the first piece and I don't think in the past that the ROC was involved in that. We'll be very involved in that because I need to - I want to control that raw material walking in the door and then I'm very intentional in as a director the classes that we have in the system now, I go talk to them and tell

them this is what we're doing.

Because apparently the culture in the past was there would be conversations had with new employees saying you're going to the ROC, they're crazy there, you know, I've got to make it, blah, blah, blah. And, no, we're -- this is -- the ultimate goal is to professionalize this operation that is it, professionalize to concentrate on our critical safety mission.

So everything that we need to touch in order to do that, that's what our goal is.

Q. I see. Do you have a vision of when, how long it would take to get to where you think you need to be?

A. Yeah, I'm giving; I'm giving us about 18 months from beginning to end and that's just to -- now it's going to be, that's going to be longer term but to get everything in place. So I need the staff in place and that engagement that comes from myself and my deputy and then from the entire managerial structure, talking with labor, you know, I've reached out to labor to have those conversations.

But just to get people to understand no matter what position they hold if they're in the ROC or outside of the ROC we have that conversation on what the intent is, which is we need to professionalize this operation because it's too critical, our safety mission is too critical to have any distractions in here, so none of that will be tolerated and we just strive towards that every day.

Q. Eighteen months, when from beginning to end and when was the beginning?
A. August 23rd.
Q. Okay.
A. That would be to me the start date on when we get -- when we put our management structure in place.
Q. I appreciate that. Thank you.
A. Yeah.
Q. I'm going to change directions a little.
A. Sure.
Q. We are here, as you know, for I'll call it the event, would you call it the event?
A. Yeah, yeah.
Q. Okay, a few days ago.
A. Yeah.
Q. Did you play -- were you here that day, did you play a role?
A. So it started at 4:51 that's when the initial notification come in, came in. I normally commute when the weather is good on a motorcycle because coming from Waldorf to here is just - it is stupefyingly slow. So I'd get on a motorcycle and I can get through traffic.

And then going home the same thing. So I got home, put the bike up, said hello to the wife and I was going to do some -- I was going to change the oil on my truck. And so as I got setup for that I got the call and it was a critical notification saying

that one of the things that I put great emphasis on is a disabled train in between platforms, that's risk, because the previous culture was to if you had that scenario was to troubleshoot the vehicle and the passengers -- I wouldn't say there wasn't a concern for them but the interest was with the broken vehicle.

What we came to find out is that you've got about 10 minutes when that occurs when a vehicle is disabled where you'll have passengers at that point will and, you know, there's always some anomalies there but from my experience being here in a short time period and for about 10 minutes they're going to do something and that something is maybe going, leaving that train and going down onto the roadway and self-evacuation.

So that's a -- we developed a system where that awareness level was raised up to say if we have that scenario, mobile train, disabled train in between platforms, we send out an alert, we get people involved with that and then we start looking at that and saying, okay, what's our timeframe, what are we going to do, rescue train to come in or do we evacuate, so all those different things.

So on the 12th when this occurred and then you also factor is it in a tunnel or is it outside of a tunnel, so all those different things came into play. When this call came it it raises up that level instantly because of the location of the vehicle and then we learned that there was a derailment also.

So there was a phone call that we use, it's a Teams call that

we use to get everybody on and we start having that conversation. But with this event or any event I'm intentional in how I engage which is I put a lot of emphasis on my deputy who I consider to be my technical SME to work the problem.

Now I'm in the background and I'm listening in and everything but I'm not jumped in and diving in because I want the Team to get that experience and work the problem because now I'm solving a couple problems, I've got helping them develop as leaders and then also development.

Because if I keep diving in I squash their ability to, you know, to learn those skills and the reason I'm adamant about that, I was -- that's how I was brought up in the FAA, so I bring that experience here.

So when this event occurred we got on the call and I was in the background and I'm texting our folks here to see if they needed anything but they were pretty calm and were working the problem.

Q. Has there been any type of debriefing regarding this incident?

A. Yeah, I talked to -- we're going to do a hot wash and that so different levels of that. We did one here internally that so the event occurred on Tuesday and it was still ongoing and active on Wednesday.

On Thursday I along with my deputy we interviewed the folks here in the ROC that were involved in the event just to get an

understanding, first of all, how were they doing but then to get their perspective from the things that occurred. A deeper hot wash will occur, so you let the investigation take place and then we'll join up probably sometime next week and have that hot wash and that will be with all the different entities that were impacted, yeah.

Q. Only if you're comfortable is there anything you can share about the internal hot wash that was --

A. Yeah. So part of the flux that occurred in the ROC in the past was this was a very -- the atmosphere and the environment was very punitive, I'll just be brutally honest with you.

Q. Was, I'm sorry?

A. Punitive. So if people made mistakes, if they had performance issues there was a process where they would be suspended up to and including 30 days with no pay and again based on my experience you can't do that because it's counterproductive.

Now we clearly we developed a process walking in the door where we clearly segregate performance issues with conduct. If you're sitting there working and as a human being you make a mistake, the system knows that and the system needs to take that information, adapt to it, learn from it and adjust.

If it's a conduct issue and Bruce doesn't want to come to work or he comes in and he's doing something that's counter to our processes and procedures we developed a process to deal with that. But clearly segregate those things.

So when we had the internal conversations we had to -- I had to lay that out to say this is not a witch hunt, just like you did where you said, we're not looking to lay blame or anything, we want verifiable factual information and that's how we're going to learn from this and get better.

And so that was that conversation. What I learned from that conversation is our folks made some assumptions which was the stuck holding brake and they bypassed what should have been the number one issue which was the report of smoke.

And so what we'll do from that is we'll do a lessons learned and there will be some retraining that's associated with that and basically that's going to be processes and procedures. The report of smoke should have superseded anything else because that's the greatest risk.

So you take that and we have a process for dealing with smoke, a report of smoke on a train, basically you have the operator go back and identify that and that should have been the first step and again it's learning from that and you do it in a non-punitive fashion.

I'm not going to suspend anybody from that because they were doing their jobs. So that -- long answer to your short question, that is my learning as a director is that we made some assumptions so I will use that as an educational piece to let our folks know, don't assume, follow the processes and trust the procedures, period and we'll go from there.

Q. Okay. So is it your belief that the processes, the way they are established or the way they exist --
A. Yeah.
Q. -- were effective to deal with this situation; however the processes were not being closely followed or entirely followed?
A. For me I think we had the processes and the procedures in place to deal with them. I think they got sort of -- the assumptions that were made, which is the stuck holding brake, we got tunnel vision on that; whereas the refocus needs to be whenever there's a report of smoke and in this scenario there was the one report of smoke where the operator said that somebody from that train or from that car called him and said, smoke is coming in or pouring in or something to that effect, that should have triggered a different response from us. It should have.

But I also, going back to that piece about the technical diversity, Abney, the person that was working the radio was a train operator in the past, so he's aware of, you know, the stuck holding brake and some of the things that that might entail with that.

But there's a refocusing that needs to take place to say, yeah, take your previous experience, sure, I got that; however prioritize what the scenario presents to you and in that case it should have been smoke no matter how brief that pronunciation was that's our priority because, again, that's our greatest risk.
Q. Okay. Let me get a little more focused about, so you

probably know yesterday we interviewed the train operator --
A. Yeah.
Q. -- and the two controllers.
A. Uh-huh.
Q. Okay. But before I ask you a question let me just -- since I don't know the world of air traffic control --
A. Yeah.
Q. -- when you're, when you're at your desk, air traffic control, do you have manuals or procedures or a checklist that you could reference?
A. We do but that -- so it's sort of a different environment because when an emergency occurs, an event occurs, everything else stops in order to address that. So it becomes -- the scenario is a little bit different because the variable here between the difference between aviation and rail, which is something I'm still getting my head wrapped around, is the whole concept of troubleshooting.

You didn't do that in aviation, right. And I think that adds a variable that I'm still -- I'll be honest with you, I'm trying to to understand that, that concept of a rail traffic controller troubleshooting an event because in air traffic you would just - if American 1521 says he has a problem we would find out what his needs were but there would be an expectation that they talked to a technical expert to deal with that issue.

And then based on that conversation we would move that

aircraft out of the way and then when he was ready to do whatever he wanted to do, whether it's land, divert to do something different, all hands on deck to make that happen.

Here the expectation and the -- well the expectation that that rail traffic controller starts to process to troubleshoot to find out what's wrong with that train, it's foreign to me and that's something that we're going to dig into deeper as we move along here. So, yeah, it's different.

Q. I'm just curious, as you're growing into your job, do you talk to other Transit agencies to see how they --

A. Yeah, that's, I've got people working on that right now because I need to know that so Atlanta, New York, Chicago, the big systems --

Q. Sure.

A. -- what do they do now? The initial reports are that's baked in two processes where they do troubleshoot as rail traffic controllers and, yeah, we're going to, we're going to explore that further to see if there's change that needs to be impacted, well, enacted with that.

Q. Okay. There's a reason I asked you about the air traffic controller if you have documents and flow charts and checklists and things like that.

A. Uh-huh.

Q. So during, during our interviews what we learned was -- and again this is just fact finding and we're not --

A. Yeah, yeah.
Q. -- we're not drawing any conclusions --
A. Sure.
Q. -- if there was a problem or not.
A. Yeah.
Q. But he had asked if the RTCs had used any type of manual or checklist --
A. Yeah.
Q. -- when they were troubleshooting and they did not.
A. Yeah.
Q. They relied on their experience.
A. Correct.
Q. So what are your thoughts about that?
A. So that's a cultural issue that one of the things in the culture that we're dealing with because I will move us away from that, I will. And part of that is my managerial staff will be trained and the expectations will be you're there, they're there to oversee the operation and specifically if we have a safety event.

So if something happens the expectation would be for a manager to be involved to make sure that those processes and procedures are being followed.

Now when you asked me about the timeframe to make that happen, I gave myself 18, I'm giving myself 18 months because life is occurring. So when we did the reorganization I have - we asked

for nine front line supervisors, they're called AOMs, assistant operations managers, and they're our first line supervisors.

I've got six of those slots currently filled. I've got two people out on FMLA, family medical leave act, because life occurs and then another individual who's in training. So have to, that's learning for me and the staff to say we need to factor that in into moving forward because I need to have -- those are critical slots that need to be filled.

And if I have somebody that goes out on FMLA or not able to assume that position then we need to have our process in place where I can move them off of that slot and have somebody available to do that, to do that function because that's going to be critical for us moving forward.

But that, you know, that's learning from coming into this environment.

Q. Right. I'm trying to see where there may be a disconnect with what your expectations are in terms of checklists and why they may not have been used in some situations. So if we were to go back to their classroom training --

A. Yeah.

Q. -- do you know how checklists are, how people are trained on it in terms of when it should be used or if and how?

A. Yeah, and I'd have to really check on that to see because I know that as like when the transformation team came in, part of that process was to institute that type of structure into the

environment and in this case I'm pretty sure that that type of training had already occurred.

But now those type of things need to be reinforced on a consistent basis. We're going to do drills, we're going to do -- there's going to be things that we do to reinforce that and say, this is what you shall do.

It's not an option, this is what you shall do in case of an event occurring.

Q. Right.

A. Yeah.

Q. Yeah. I'm being -- my colleagues here are --

A. Yeah.

Q. I've learned of a 2015 FTA report.

A. Yeah.

Q. A 2019 safety oversight report that had identified well things that you said, chaos in the operation and so --

A. Uh-huh.

Q. -- I'm not sure if it specifically mentioned use or non-use of checklists.

A. Yes.

Q. So people here, your predecessors were aware of some type of issues that were identified and this event, you know, again no conclusions on our part.

A. Yeah, yeah.

Q. But we have to look at if the previous areas of concern have

been identified, you know, we'll look at --

A. Yeah.

Q. -- are they continuing on, is something you'll look at as well?

A. Absolutely, absolutely. And to me it comes down to and not to minimize anything, there is, there is a need for a change of culture in this environment and that's pretty big, it really is because if people were used to doing things for an extended period of time that's what they're going to fall back on.

Part of the `19 audit, if I recall correctly, there was -- the culture was the folks weren't allowed, the specialists weren't allowed to use checklists. I think and correct me if I'm wrong, Bruce, I think that was an idea identified where they were told to do -- they were given instruction on how to do it from managers and I think that was part of the issue.

So walking in the door there will be check issues, there will be structure in this environment because basically I'm not going to accept somebody telling me I'm relying on my knowledge or memory of a situation, of a process in order to alleviate or to mitigate it.

No, we have a checklist here, take the checklist up, follow the checklist from A to Z. You asked the question, did we do that in air traffic? If we had -- on certain events we did, everything was electronic, you'd punch it up on your screen, you'd pull up your checklist and you'd just follow that, and that's how you get

out of that event.

And when people circumvent events things happen. One that sticks with me that was just absolutely heartbreaking, the Asiana crash in San Francisco where the two young ladies were killed because they had sprayed the foam and they didn't follow the process in order to, you know, clear all the passengers out and things like that.

So that's our focus, we don't want people getting hurt while they're using this system, that's the bottom line. Safety is number one and, you know, these are the things that we put in place in order to make sure that that happens so.

Q. I appreciate all your responses here, thank you.

A. Okay.

Q. So I'm going to move on. Do you need a break or anything?

A. No, I'm good, I'm good.

MR. JENNER: Okay, we'll move on to Greg.

BY MR. KUPKA:

Q. Hi, this is Greg Kupka. Just real quick, are the AOMs Rail 2 or Rail 3?

A. So the Rail 2 and Rail 3 is a position that it will be the AOMs, yeah.

Q. Okay.

A. Yeah. So they are assigned to either Rail 2 or Rail 3 position.

Q. Okay, very good. And so what would be the expectation for

the AOMs to interact with the RTCs we spoke to yesterday?
A. So during that event and again because of those reasons where I don't have a full contingent of the AOMs we have it setup where Rail 2 would be involved with the actual and Rail 2, we have Rail 2 and Rail 3 and sometimes I get them mixed up, excuse me.
But one is designated to be -- to manage the event.
Q. Okay.
A. So the expectation would be you go down to that console and you just observe and making sure that things are being followed, those procedures are being followed as lined out. The Rail 3 would manage the rest of the railroad while that event was going on.
Q. So if one of the RTCs needed assistance they could just raise their hand or somehow call?
A. Yeah, because they would be there, they would physically be there.
Q. Okay.
A. And again that's the intent to have that managerial presence to assist in that process.
MR. KUPKA: Okay. That's all I have. Bruce.
BY MR. WALKER:
Q. So, Ed, I'm just -- if you could just help me procedurally is, we identified some areas where checklists weren't followed.
A. Yeah.
Q. Which is okay, there's room for improvement.

A. Yeah.
Q. What is, what is the internal process that you have in place? I know that you did a hot wash but can you walk me through what you, what your team is doing to review what happened and what kind of reports are generated, so that we can minimize this going forward?
A. Yeah. So we've got and as we put these things in place, so we're still in the process of putting things in place. So right now our after action reports or the hot wash, we've got a process defined for the after action reports, it just has to be signed off and instituted and trained on right now, so it still is probably about 75 to 80 percent where it needs to be.

But what we're going to do with that is for me anytime we have an event and we pull it apart the intent is to learn from it, that's going to be our key. So we'll train on it, we'll identify it, see what the risks that were introduced into the system, mitigate those risks and then train our people and share that information, because I don't know if that was done in the past.

So long answer to your short question, that's still the work in progress but what we'll do right now, the interim procedures are we'll sit down, we'll have conversations with the folks, identify any gaps that were there and we'll share that information with the rest of the workforce.

So sometime next week I'll gather up all this information and I'll identify that when this event occurred there was an initial

report of smoke. We did not follow the smoke in a cab or smoke in a car procedure. With the stuck holding brake, you know, the troubleshooting and things like that, honestly if we had followed the smoke procedure I don't think we would have got to -- there wouldn't have been much emphasis placed on the stuck holding brake.

Because car maintenance and a rail supervisor were on a train coming in on Track 1 from Roslyn towards Arlington and they were let off, I think, within five to 10 minutes of this event occurring. And so that's -- ideally for me that's where we get to.

You have experts that you have car maintenance, you have rail supervisors that responsibility should lie with those experts to diagnose what's going on. We stabilize the situation and allow those folks to get in.

Now if it's stable where, you know, there aren't smoke or any variables like that, then that's a luxury to have but, you know, each situation is going to be different but that's where I would like to get us to.

Q. Okay. And then my final question is is that you seem to place kind of an emphasis on the rail controller's troubleshooting an event, do you have some other solution in mind other than the rail controller's troubleshooting or what is it you're thinking?

A. I don't know, Bruce. I don't know and honestly that's learning for me because it's foreign to me. It is truly foreign.

To go back to what Steve was saying, as far as the whole concept of an individual that's responsible for maintaining the operation, you know, to watch the operation you're troubleshooting, you're trying to diagnose what's wrong with that train if it's disabled or stricken in some way.

My, my take on it is, you have car maintenance, you have that entire entity that should be dedicated to that so if something happens we isolate that vehicle, we take care of the passengers, if we have to evacuate them or bring a rescue train in or anything to that.

But you isolate that train and then that gives us the time to single track around it and let the experts go in and diagnose what's wrong with it.

Q. Okay. And you said something that triggers one last question for me. Rescue trains, so I was reviewing the MSRPH, there's times in there for a rescue train, can you just explain to me from your understanding when is a rescue train utilized to evacuate customers versus the fire department and what's the determination on that?

A. Yeah, it would be situational and you would rely again -- the technical experience in WMATA is vast. You have that so that would be a conversation to say, we have a train that's disabled in between platforms, are we -- do we have a scenario where the environment, there's no fire or anything like that present or anything, where we can bring a train in, evacuate those customers

off of that train, move them to the next available platform and remove that variable from the situation.

And so it's situational and it would be based on a conversation with the folks, senior leadership and the folks involved in making those type of decisions.

Q. That makes sense. So the passengers were on the vehicle for somewhere between an hour and a half to two hours until the last customer was off, so at what point would the rescue train be triggered?

A. Well, in that case because of the derailment and we had to take down (indiscernible) power because Arlington County's response was relatively quick, they got there to the scene relatively quickly.

I don't -- I'd have to look at the timeline to see when they got there but the variable in that where a rescue train wasn't brought into the equation was taking out their real problem, so if we -- if you keep power up you can bring a train in to evacuate them but absent that you just can't do it.

MR. WALKER: Thank you, that's it. Thank you, Steve.

MR. DONALDSON: And also with that, just to -- not to belabor that but with the derailment we did -- once we found out that that car was derailed, you don't know what caused that, it could have been an issue with the track or something like that, so you don't bring something else into that environment without, you know, having full knowledge.

MR. WALKER: Thank you.

MR. JENNER: Very good. Actually I do not have any questions. I look at my fellows here, okay, anything else?

(No audible response).

MR. JENNER: Thank you for your frankness and insight. Is there anything that you can think of that will help us in the investigation, like we should talk to or examine?

MR. DONALDSON: Like I said, I'm familiar with the NTSB's inner process, you guys got this, you guys got this stuff, I mean, you're very thorough on the things that you do. My perspective, just to close out my comments, I give WMATA credit bringing an individual like me in is totally different than, so that to me that shows a willingness to do something different, to get a different perspective so I commend them for that.

I commend the folks, the GM, Andy (indiscernible), Jamie Johnson, there is a commitment to do things differently and so we're faced with, you know, we're running this race to keep the railroad running while we institute these changes so but there is definitely a commitment to that.

Everything that, you know, me walking in the door that's been asked for has been granted and I think that's, that's pretty huge. Removing, I'll just simply say the distractions from that environment is a commitment.

So you've got the effort and the commitment is here, it has just taken us a little bit of time to get things in place so.

Yeah, yeah, that's it.

MR. JENNER: Very good. I want to thank you for coming in today.

MR. DONALDSON: Okay.

MR. JENNER: It's 11:32 and that ends the interview.

MR. DONALDSON: All right.

(Whereupon, at 11:32 a.m., the interview was concluded.)

CERTIFICATE

This is to certify that the attached proceeding before the

NATIONAL TRANSPORTATION SAFETY BOARD

| | |
|---|---|
| IN THE MATTER OF: | WMATA METRO TRAIN DETAILMENT<br>IN ARLINGTON, VIRGINIA<br>ON OCTOBER 12, 2021<br>Interview of Ed Donaldson |
| ACCIDENT NO.: | RRD21MR017 |
| PLACE: | Landover, Maryland |
| DATE: | October 16, 2021 |

was held according to the record, and that this is the original, complete, true and accurate transcript which has been transcribed to the best of my skill and ability.

Cheryl Farner Donovan
Transcriber